

WRMA

Walter R. McDonald & Associates, Inc.

FINDINGS FROM THE

SERVICE AREA 4 FOCUS GROUPS

CONDUCTED FOR THE MENTAL HEALTH SERVICES ACT
PREVENTION AND EARLY INTERVENTION PLAN
IN LOS ANGELES COUNTY

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Prepared for:

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I. Introduction

The Los Angeles County Department of Mental Health (LACDMH) is engaged in an intensive, inclusive, and multi-faceted approach to developing the County's Prevention and Early Intervention (PEI) Plan to be funded through the Mental Health Services Act (MHSA) enacted by California voters in 2004.

The focus for developing the PEI Plan is at the Service Area level, utilizing informational meetings, key stakeholder interviews, focus groups, and community forums in each of the eight geographic areas of Los Angeles County. Because each Service Area has distinct and varying populations, geography, and resources, it is critical for PEI services to be specific and responsive to regional and community-based needs.

The California Department of Mental Health (CDMH) has defined *mental health prevention* as reducing risk factors or stressors, building protective factors and skills, and increasing support to allow individuals to function well in challenging circumstances. Whereas, *mental health early intervention* involves a short duration (usually less than one year) and relatively low-intensity intervention to measurably improve a mental health problem or concern early in its manifestation and avoid the need for more extensive mental health treatment or services later.

In addition, CDMH has targeted five community mental health needs, six priority populations, and six statewide efforts for the PEI Program, and has identified seven sectors that counties must partner with to develop their PEI Plan.

This report presents the findings from the Focus Groups conducted in Service Area 4. Each service area will receive a report of the findings specific to the focus groups selected to speak on its behalf. In addition, a comprehensive final report will be produced presenting aggregate findings across all of the focus groups conducted in Los Angeles County.

II. Methodology

Participants

Each focus group was comprised of no more than 10 participants. Participants were drawn from existing groups/agencies for the purpose of participating in a discussion about the mental health service needs, barriers, and strategies in their respective communities.

- As with the Key Individual Interviews, the focus groups were selected based on Service Area representation and the categories of MHSA age group, sector, priority population, and key community mental health needs for PEI. Utilizing recommendations made from LACDMH District Chiefs, Service Area Advisory Committee (SAAC) members, and other stakeholders throughout the county familiar with the categories, LACDMH selected focus groups that qualified in at least two PEI categories.
- LACDMH identified a focus group coordinator from each community group/agency selected. The focus group coordinator sought participation in the focus group from among the agency's membership. Focus group coordinators were asked to identify and invite a diverse group of participants who could speak about service needs, barriers, and recommended strategies for their Service Area.

Participating Agencies

A total of 50 individuals from the following six agencies in Service Area 4 were asked to participate in their respective focus group:

1. Coalition to Abolish Slavery and Trafficking (CAST-LA);
 2. Coordinating Council on Runaway and Homeless Youth;
 3. Homeboy Industries;
 4. Asian Pacific Counseling and Treatment Center (APCTC);
 5. Search to Involve Pilipino Americans (SIPA); and,
 6. Skid Row Advisory Group.
- Five of the six participating agencies from which the focus groups were drawn have been in existence between 1 year and 22 years. The same five agencies support between 7 and 45 members or more. One agency did not provide information on the number of years in existence or the number of members it supports.
 - Across the six participating agencies, members ranged in age from 16 to over 60, with three participating agencies represented by adults only; and one agency represented by adults and older adults. Two agencies represented transitional-age youth and adults.
 - With respect to ethnic composition, four of the six agencies represent the Latino/Hispanic community. Four agencies represent the Asian Pacific Islander community, specifically the Chinese, Pilipino, and Vietnamese communities. Three agencies represent the African American community and two agencies represent the Caucasian community.
 - Finally, the following community sectors in Service Area 4 are represented across the six agencies: Community Family Resource Centers, Education, Employment, Health, Individuals with Serious Mental Illness, Law Enforcement, Social Services, and Underserved Communities.

Procedures

Each focus group coordinator worked closely with a member of the contracted consulting team to arrange focus group dates, times, and locations.

The focus groups were conducted at the organizations or agencies representing the focus group participants or other community-based locations. The focus groups were audio recorded and took about two hours to complete. Nine key questions, some of which contained sub-questions, were posed to focus group participants. The questions were designed to produce information needed to inform the PEI planning process. A copy of the Focus Group Guide can be found in **Appendix A**.

Facilitators representing LACDMH at the focus groups as a neutral third party included a team of three staff members from Walter R. McDonald & Associates, Inc. (WRMA) and their subcontractors, EvalCorp Research & Consulting, Inc., and Laura Valles and Associates, LLC. One team member facilitated the focus group, another observed and documented notes, and a third recorded participants' responses on flip charts, which participants could refer to throughout the focus group.

Focus group documentation included: a Focus Group Profile, a Focus Group Participant Profile, a signed Consent Form indicating that the focus group would be audio recorded, the observer's electronic notes, the paraphrased responses from participants, an audio recording of the focus group, and a transcript of the focus group developed from the audio recording. A report was written by the

focus group team observer, summarizing the group's responses to the questions. Information from each focus group was coded so that the data could be analyzed and presented in summary format.

III. Knowledge of the PEI Planning Process

Participant Participation in the PEI Planning Process (Q1)

The first question(s) that focus group participants were asked to answer was "Have you or your group taken part in the Los Angeles County Department of Mental Health's PEI planning process? And, if so, how?" Nine of 50 participants reported having some experience with or participation in the PEI planning process. Of these participants, eight from one focus group had served on Ad Hoc Committees, attended Service Area Advisory Committee meetings, and participated in brainstorming sessions with program managers; and, one from another focus group had attended PEI meetings with physicians and family members at the Department of Mental Health.

IV. Service Area and Priority Population Representation

Service Area (Q2)

When focus group participants were asked which service area they represent, 38 indicated that they represent Service Area 4, and seven indicated that they have countywide representation. Other service areas represented by 14 participants were: Service Area 1 (n=2); Service Area 2 (n=4); Service Area 5 (n=1); Service Area 6 (n=5); and Service Area 8 (n=2). Additionally, nine focus group participants felt it important to recognize that they represent Skid Row first and foremost. Similarly, one participant predominantly represents Pico Union and Boyle Heights.

Priority Populations (Q2a)

The CDMH has identified the following six priority populations for PEI services: 1) Underserved cultural populations; 2) Individuals experiencing the onset of serious psychiatric illness; 3) Children and youth in stressed families; 4) Trauma-exposed individuals; 5) Children at risk for school failure; and, 6) Children and youth at risk of or experiencing juvenile justice involvement. Focus group participants were asked to select the priority populations they represent. As shown in **Table 1**, of the six priority populations, a majority of the participants represent three of them. Between 60 and 64 percent of participants identified Trauma-exposed individuals (64%), Children at-risk of school failure (62%), and Children and youth in stressed families (60%) as priority populations in their communities. Fifty percent of participants represent Underserved cultural populations alongside Individuals experiencing the onset of serious psychiatric illness; and, fewer than 50 percent of focus group participants represent Children and youth at-risk of experiencing juvenile justice involvement.

Table 1: PEI Priority Populations

PEI Priority Populations	Number of Participants	Percent of Participants (n=50)
Trauma-exposed individuals	32	64%
Children at- risk of school failure	31	62%
Children/youth in stressed families	30	60%
Underserved cultural populations	25	50%
Individuals experiencing the onset of serious psychiatric illness	25	50%
Children/youth at-risk of or experiencing juvenile justice involvement	23	46%

V. Community Mental Health Needs and Impacts

Mental Health Needs in the Community (Q3 and Q3a)

Each focus group participant identified the mental health needs in his/her community based on five MHSA categories: 1) Disparities in access to mental health services; 2) Psycho-social impact of trauma; 3) At-risk children, youth, and young adult populations; 4) Stigma and discrimination; and, 5) Suicide risk.

Sixty percent of focus group participants identified Disparities in access to mental health services and Psycho-social impact of trauma as top mental health needs in their communities. At-risk children, youth, and young adult populations were identified as the next greatest mental health need by 54 percent of focus group participants. Closely following At-risk children, youth, and young adult populations was Stigma and discrimination at 50 percent. Another need identified by one-quarter of participants was Suicide risk (24%).

Table 2: PEI Mental Health Needs

PEI Mental Health Need	Number of Participants	Percent of Participants (n=50)
Disparities in access to mental health services	30	60%
Psycho-social impact of trauma	30	60%
At-risk children, youth, and young adult populations	27	54%
Stigma and discrimination	25	50%
Suicide risk	12	24%

When asked to identify the top three mental health needs from among the list of five determined by CDMH, Psycho-social impact of trauma emerged as the top priority among five of the six focus groups (see **Table 3**). The following two additional mental health needs tied for the second priority: Disparities in access to mental health services, and Stigma and discrimination. At-risk children, youth, and young adult populations was the third priority mental health need selected by three focus groups. It should be noted that two focus groups did not identify a second or third priority mental health need because they felt that the mental health needs remaining after the top priority had been selected were all important and interrelated.

Table 3: Priority PEI Mental Health Needs

Priority PEI Mental Health Needs	Number of Groups (n=6)*	Priority
Psycho-social impact of trauma	5	1
Disparities in access to mental health services	4	2
Stigma and discrimination	4	2
At-risk children, youth, and young adult populations	3	3

*Two focus groups did not identify a second or third priority.

Impact of the Mental Health Needs on the Community (Q4)

As presented in **Table 4**, focus group participants reflected upon and relayed the negative impact that the unmet mental health needs discussed in the previous section have had on their communities. The four most highly mentioned impacts were community and family violence and abuse, service access, and the poor social and economic conditions in the communities coupled with the breakdown in community and family infrastructure.

Community and family violence was the most highly mentioned impact, and focus group participants reported high incidents in the following areas: gang and/or mafia involvement and activity, vandalism, kidnapping, and general violence in homes, schools, and community neighborhoods. With respect to family violence and abuse, focus groups reported an increase in rape and child abuse.

With respect to access issues, the second most highly mentioned community impact, focus group participants noted that stigma and discrimination are widespread and greatly contribute to the disparities in access to mental health service provision in the community. Participants revealed that stigma and discrimination lead to a tremendous amount of guilt and shame that hinders people from getting the services they need. Without services to address their mental health problems, they become at-risk of acting out in violent or anti-social ways. Other access issues that impact the mental health of the community are: difficulty accessing services, lack of transportation, and language barriers.

“Our parents never really talked to us about mental health. ...to us talking about mental health stuff means you are kind of crazy. We would be even more misunderstood if we talked about these things because society already labels us negatively by the way we look and where we live.”

A number of social and economic conditions also impact and contribute to the erosion of community and family infrastructure. Specifically, focus group participants cited extreme poverty, homelessness, and unemployment as the primary contributors. Participants also indicated a lack of family unity and divorce as impeding the social-emotional well-being of communities.

“...in South Central, you have large numbers of children basically raising themselves. Their parents are working, absent, ill, or high. They find school boring because the children think their teachers are just as bad as their parents. Many of these kids spend their time riding dirt bikes and playing with illegal weapons .”

Focus group participants also pointed out how the community is affected by the lack of suicide prevention programs and the increase in substance abuse. Those who are returning from prison are especially at-risk of drug relapse or other behaviors that violate the conditions of probation, indicated one focus group. Also, families who are working multiple jobs leave children and youth unsupervised and without parental support, inviting a potentially unhealthy state of affairs. According to one focus group, children who grow up in families who live under very stressful circumstances often exhibit mental

health symptoms at some point in their childhood and/or youth. When left unaddressed, these symptoms likely become further exacerbated, and then negatively impact the whole family.

Other community impacts cited, but not mentioned as often as those reported above are:

- High truancy and drop out rates.
- Increased acting-out and unmanageable behavior in pre-schools and beyond.
- Youth engaging in negative and risky behaviors such as unsafe sex and prostitution.
- Inability to address mental health issues, due to a lack of knowledge about mental health symptoms and available services.
- Existing laws that make it difficult to care for mentally ill patients.
- When mental health concerns are dismissed or denied by service providers, families become discouraged and do not seek other assistance.
- An overall increase in health care problems.
- Lack of maintenance and follow-up programs after initial services have been sought and received.
- Those recently released from the juvenile justice system feel alone and lack the services they need to assist them in making a healthy transition to neighborhood and family life.

“...children as young as pre-school are already showing signs of emotional instability. Some studies are beginning to suggest that problems with this population may be a significant precursor of school drop out later.”

**Table 4: Ways in which Mental Health Needs
Impact the Community**

Community Impact	Number of Mentions
Community/Family Violence/Abuse	9
Access Issues	8
• Stigma and Discrimination	5
• General	1
• Geographic Location/Social and Physical Conditions/Transportation	1
• Service Linguistic/Cultural Competency	1
Social/Economic Conditions	8
Community/Family Breakdown/Hopelessness	7
Mental Health Issues	4
• Substance Abuse	3
• Depression/Suicide Risk	1
Families/Parent High Stress Levels/Parenting Issues/Poor Social Skills/Coping	3
Unaddressed/Exacerbated Mental Health Conditions/Higher Levels of Care/Poor Social Conditions	3
Academic Outcomes	2
Negative Risky/Behaviors	2
Outreach/Education/Awareness-Available Services	2
Political/Legal/Educational/Social Systems	2
Service Engagement/Benefits	2
Behavioral/Social/Emotional/Outcomes	1
Health Care Issues	1
Service Integration/Continuity of Care	1
Support System	1
Other	3

VI. Existing and Needed Prevention Services/Resources

Existing Prevention Services/Resources (Q5)

The following is a listing of all the existing prevention services identified by participants across all six focus groups. Please note that one focus group felt that available prevention services are insufficient; two focus groups emphasized the value of their own agencies in the community, but also listed additional services when prompted to do so.

- After school programs, similar to those at Search to Involve Pilipino Americans (SIPA) or LA Best.
- After school programs, especially sports and art programs.
- Alexandria House:
 - after school programs;
 - teen programs;
 - child care; and,
 - shelter for women and children.
- Asian Pacific Counseling and Treatment Center (APCTC).
- “Because I Love You,” works with parents to improve outcomes of children.
- Blood Bank, comes to local colleges and encourages people to donate.
- Boys and Girls Clubs.
- City of Hope.
- City of Los Angeles, offers summer jobs for youth.
- Coalition to Abolish Slavery and Trafficking (CAST-LA).
- Collaborative Housing Program, places people without available funding.
- Collaborative Housing, available to those who receive mental health services.
- Child Abuse Prevention.
- El Centro del Pueblo in Echo Park, provides after school programs.
- Enrichment, education, and community building services.
- First 5 LA, stabilizes and supports mothers to bond with and raise their children.
- Food Bank, also provides fresh produce.
- Good Shepherd, provides services for homeless women and children.
- Harm reduction and diversion programs.
- Head Start.
- Homeboy Industries, offers a variety of employment-related services to at-risk youth and those involved in the juvenile justice system.
- Identification and Assessment services.
- LA’s BEST-after school programs.
- Legal Aid.
- Legal services.
- Los Angeles County Office of Education, alternative high schools.
- Los Angeles County Parks and Recreation Department, a variety of services including open access swimming pools.
- Los Angeles County Probation Department, school-based programs.
- Mental health awareness campaigns.
- Parent involvement, provides opportunities for parents to spend time with their children, and raises their awareness of what their children are doing.
- Parenting groups, works on developing parent-child bonds early on among families in which either the parent or child has been identified with a mental illness.
- Parenting programs.
- School-based parenting classes.

- Self-help support groups, such as Families Anonymous, and Kleptomania & Shoplifters Support.
- Services designed to focus on environmental risk factors and provide alternative environments or help individuals find alternative environments.
- SHARE program in Marina Del Rey.
- Search to Involve Pilipino Americans, after school program.
- St. Anne's Home for Girls.
- Training for parents with special needs children.
- Village Health Foundation, offers services similar to Wellness Works.
- Wellness promoting services, promote wellness without labels.
- Wellness Works in Glendale, provides low cost healing arts, yoga, acupuncture, and wellness workshops.

Needed Prevention Services/Resources (Q5a)

All six focus groups identified a number of needed prevention services and/or resources as reflected by the list below. The needed prevention services are organized by type of service/resource and listed from highest to lowest number of needed services/resources cited under each service/resource type.

Specific Services and Resources including Counseling and Support Groups

- A discreet women's shelter.
- Homeless women's shelter for domestic violence/rape crisis.
- Family housing in communities of need with supportive services.
- Recovery programs, specifically those that provide housing and allow children to stay with their parent.
- Culturally-relevant parenting programs.
- Parenting classes in general.
- Family preservation services.
- Tutoring programs.
- Legal aid for consumers of mental health.
- Library programs and services designed for young people.
- Low cost, high quality child care.
- Counseling or help at churches, private hospitals or at the County Hospital
- Mentor programs.
- Peer-based services (youth helping youth).

Specific Strategies and Approaches

- Services that build community infrastructure.
- Adopt a "housing first" approach instead of "treatment first" approach.
- Targeted assistance for homeless women experiencing domestic/sexual violence.
- Affordable job training.
- Job security.
- Vocational education that leads to well paying jobs.
- Help for parents to negotiate with the schools and the Department of Children and Social Services.
- Smaller classrooms, nicer schools, caring teachers.
- Programs that facilitate educational field trips for at-risk youth.
- Services for low-income people and those without health insurance.
- Services for undocumented immigrants.
- Assistance with family reunification.

- Support for parents to raise healthy and happy children.

Services and Resources that Increase Access

- Increased number of qualified Medi-Cal counseling services.
- Transportation services to treatment facilities in general.
- Transportation for the homeless.
- Culturally competent services.
- Bi-lingual staff.

Outreach, Education, and Awareness Services and Resources

- Outreach and education to promote available counseling services.
- Outreach within communities.
- Mechanisms for communicating available services.
- Advertisements about available programs.
- Comprehensive materials in multiple languages.

Location-based Services

- Community-based services.
- Recreation and community centers that address cultural needs.
- Recreation centers for children.
- Faith-based support for children and families.
- School-based counseling for children and their families

Staff and Provider Education, Training, and Recruiting

- Staff trained to provide prevention services in a professional manner.
- Training for teachers to assist youth with mental health issues.

Assessment, Identification, and Early Assessment

- Early evaluation and assessment of mental health needs.
- Early identification services at medical health centers or with primary care physicians.

Services that Address Social/Economic Conditions

- Build a more powerful social and economic infrastructure to improve the lives of community members and the homeless.

Collaboration/Partnerships/Teams

- Collaborative mechanisms to breakdown disparities among providers and consumers.

Support System

- More community support.

Other

- Educational scholarships.

Priority Prevention Services/Resources (Q5b)

When the six focus groups were asked to prioritize the needed prevention services they had listed in response to the prior question, four of the six focus groups identified three priority services, as presented in **Table 5**. Two focus groups did not prioritize the needed prevention services. Please note that the priorities listed in **Table 5** are not listed in rank order.

The priorities identified by the four responding focus groups reflect prevention services and/or resources that would:

- Support programs for parents in general, as well as those that foster attachment between parent and child.
- Offer counseling services.
- Prevent gangs and gang involvement.
- Grant housing with comprehensive services.
- Deliver services at no or low cost to the general public, making sure that undocumented immigrants have access.

Table 5: Priority Prevention Services/Resources (n=4)*

Focus Group	Priority 1	Priority 2	Priority 3
Coordinating Council on Runaway and Homeless Youth	Programs that support parents.	Programs that foster attachment between parents and children.	No response.
Homeboy Industries	Gang prevention services.	No or low cost services.	No response.
Search to Involve Pilipino Americans (SIPA)	Parenting programs.	Counseling.	Services for undocumented immigrants.
Skid Row Advisory Group	Housing with comprehensive support services.	No response.	No response.

Note: Priorities not listed in rank order.

*Two focus groups did not prioritize the needed prevention services.

“Right here with Father Greg and Homeboy we can make a lot of things happen. Father Greg teaches us that mental health is an important part of our overall health. Everyone trusts Father Greg and here they make it safe for us to be real about mental health, self-esteem, and all about that. Homeboy is really the only place we can talk about these issues.”

Locations for Prevention Services/Resources (Q5c)

Table 6 presents the locations at which the focus group participants would like to see prevention services offered.

As shown in the table, locating prevention services at or near schools was the most preferred by all three of the responding focus groups. Three of the six focus groups did not provide locations for prevention services. Other locations cited by one of the three responding focus groups were childcare centers, churches, community centers, family resource centers, hospitals, neighborhood friendly locations, and park and recreation centers. One focus group, Search to Involve Pilipino Americans (SIPA) advocated for housing prevention services at its service locations.

Table 6: Prevention Service Locations

Prevention Service Locations	Number of Groups (n=3)*
Schools	3
Child Care Centers	1
Churches	1
Community Centers	1
Family Resource Centers	1
Hospitals	1
Neighborhood Friendly Locations	1
Park and Recreational Centers	1
Search to Involve Pilipino Americans (SIPA)	1

*Three focus groups did not provide prevention service locations.

VII. Existing and Needed Early Intervention Services

Existing Early Intervention Services/Resources (Q6)

The following is a listing of all the existing early intervention services identified by the participants across the six focus groups. Please note that four focus group had some difficulty identifying early intervention services. The participants in one of the four focus groups pointed out that they were only aware of the prevention services they had identified previously. Two others advocated for early intervention services provided by their agencies, as well as some additional services. The fourth focus group was able to identify only a few existing early intervention services.

- 12-step Programs.
- Amanecer, provides alcohol rehabilitation services for youth.
- Alexandria House:
 - after school programs;
 - teen programs;
 - child care; and,
 - shelter for women and children.
- Asian Pacific Counseling and Treatment Center (APCTC).
- Blood Bank, comes to local colleges and encourages people to donate.
- Boys and Girls Clubs.
- Case management.
- Churches and Faith-based Organizations.
- City of Hope.
- Coalition to Abolish Slavery and Trafficking (CAST-LA).
- Coordinating Council on Runaway and Homeless Youth.
- Department of Children and Family Services.
- Drug Rehabilitation Centers.
- Family Meetings and Intervention.
- Food Bank, also provides fresh produce.
- Good Shepherd, provides services for homeless women and children.
- Healthy Start.
- Homeboy Industries.
- Los Angeles Unified District Homeless Program.
- Legal services.

- Outreach groups, active countywide.
- Outreach groups, specifically for the homeless.
- Parenting education, teaches parents how to bond with children, particularly for those families in which either the parent or child has been identified with a mental health problem.
- Public Defenders Office, identification as a first step toward intervention.
- Say Yes.
- School counseling services.
- School on Wheels.
- SHARE program in Marina Del Rey.
- Search to Involve Pilipino Americans (SIPA).
- Skid Row Assessment and Evaluation Team.
- Victory Outreach Ministries.
- Village Health Foundation, offers services similar to Wellness Works.
- Wellness Works in Glendale, provides low cost healing arts, yoga, acupuncture, and wellness workshops.

Needed Early Intervention Services/Resources (Q6a)

All six focus groups identified a number of needed early intervention services and/or resources as reflected by the list below. The needed early intervention services are organized by type of service/resource and listed from the highest to the lowest number of needed services/resources cited under each service/resource type.

Specific Services and Resources including Counseling and Support Groups

- Housing programs.
- Section 8 housing.
- Shelters (for women and children).
- Independent living programs.
- Job training programs.
- Legal assistance for survivors of trafficking.
- Case management.
- More social services.
- Police services.
- Parenting classes.
- Services for emancipated foster youth, including housing.
- Support services for young people with special needs, especially learning disabilities.
- Services for young children.
- Substance abuse programs.
- Drug rehabilitation programs for young people under eighteen.
- Community support groups.
- Mental health support groups in schools.
- Self-help groups that link individuals as peers and promote cross-pollination among different types of individuals.

“We always keep on talking about the youth, but sometimes it’s the parents too.... Because sometimes I get embarrassed with myself, when I think that I am the problem.”

Specific Strategies and Approaches to Service Delivery

- Housing first approach with a range of available housing and comprehensive support services.
- Housing programs that specialize in helping those people who leave the criminal justice system.
- A trauma-informed integrated services plan for early intervention.
- Trauma-informed family preservation programs.
- Early intervention support for patients.
- Nutrition education and food provision.
- Programs that foster healthy social-emotional family relationships, dynamics, and overall well-being.
- Programs to build self-confidence/development.
- Programs that provide face-to-face contact.
- Strategies for self-help and relaxation.
- Meditation and yoga.
- Cultural activities similar to the Lotus Festival, Tofu Festival, etc.
- Programs that provide self-help materials and tools to develop effective coping strategies when symptoms are identified.
- Programs specializing in lesbian, gay, and transgender youth.
- Programs that address the effects of domestic violence on young children.
- Programs that support families of youth in the juvenile justice and child welfare systems.
- Need for accessible and convenient transportation services to reach programs

Location-based Services

- Recreational and community centers that provide social spaces.
- School-based services that prevent young people from dropping out of high school.
- Religious institutions with community programs run by trained clergy.
- Easily accessible services in local communities where residents live.

Services and Resources that Increase Access

- Financial assistance.
- Medi-Cal.
- Better public transportation in order to access services, including bus passes, tokens, and vouchers.

Outreach, Education, and Awareness Services and Resources

- Services that increase the community's knowledge about available services and mental health symptoms.
- Education and information about medication and medication management.

Collaboration, Partnerships, Teams

- Community partnerships.

Funding and Resources

- Continued funding for funding for programs that assist immigrants.

Priority Early Intervention Services/Resources (Q6b)

As shown in **Table 7**, three of the six focus groups participated in the prioritization of the early intervention services cited above. Please note that the priorities listed in **Table 7** are not listed in rank order.

The early intervention priorities identified by three of the six groups reflect early intervention services and/or resources that would:

- Provide age-appropriate services.
- Engage DCFS programs.
- Offer parenting classes.
- Establish community support groups and 12-step programs.
- Make use of police services.
- Develop a housing first model that includes comprehensive support services.
- Create social spaces for consumers, such as recreational and community centers.

Table 7: Priority Early Intervention Services/Resources (n=3)*

Focus Group	Priority 1	Priority 2	Priority 3
Coordinating Council on Runaway and Homeless Youth	Age-appropriate services.	DCFS programs.	12-step programs.
Search to Involve Pilipino Americans (SIPA)	Parenting classes.	Police services.	Community support groups.
Skid Row Advisory Group	Housing first model with a range of available housing and comprehensive support services.	Recreational and community centers that provide social spaces for consumers.	No response.

*Three focus groups did not identify early intervention priorities.

Note: Priorities not listed in rank order

Locations for Early Intervention Services/Resources (Q6c)

Table 8 presents the two locations at which the Search to Involve Pilipino Americans (SIPA) focus group would like to see early intervention services offered: at hospitals and at its own agency. None of the other five focus groups provided locations for early intervention services.

Table 8: Early Intervention Service Locations

Early Intervention Service Locations	Number of Groups (n=1)*
Hospitals	1
Search to Involve Pilipino Americans	1

* Five focus groups did not provide preferred locations for early intervention services.

VIII. Barriers to Service Access and Strategies to Increase Access

Barriers to Service Access (Q7)

Focus group participants were asked “What keeps people from getting the prevention and/or early intervention services they need?” In response, Service Area 4 focus group participants primarily focused on various access issues. **Table 9** shows that the top barriers to service access cited by participants were: stigma and discrimination and lack of trust in the mental health system; closely followed by transportation; then cost, insurance, and eligibility criteria; as well as the linguistic and cultural competency of services; issues with the way services operate; and the dearth of available services.

“A friend of our family has schizophrenia. On our part, we had already noticed that something was wrong with that person, but the reaction of the person’s family is that –he’s just being himself, it’s his personality. They found out later that his sickness, schizophrenia, gets worse in your late teens to early twenties. So when they took him for evaluation his condition was already severe.”

With respect to stigma and discrimination, participants stated that there is a general fear of receiving services and lack of trust that the services received will make any difference in their lives. When focus group participants expressed their fears, they talked about the fear of receiving services, and provided the following specific examples: the fear and shame of being labeled as “crazy;” the fear of being denied services; the fear of encountering someone they might know, like their employer; the fear of becoming dependent on psychotropic medication; and the fear of social prejudices. Concerning trust, one focus group talked about the lack of confidence consumers have in service results, which leads people to not engage in improving their mental health, but instead to focus on day-to-day necessities such as providing for their families.

Transportation to and from services was less mentioned than stigma and discrimination, but still considered a key barrier to access. Similarly, restrictive eligibility criteria, not having Medi-Cal, off-putting paperwork, and other cost and insurance issues, also impede community members’ ability to obtain the services they need. Language access is another area that needs attention according to participants. One focus group explained that when people come from different countries and they do not speak English, they do not know how to express themselves, let alone explain to the mental health professional how they are feeling and what may be bothering them. In addition to language barriers, participants have experienced breakdowns in confidentiality, mistreatment by professionals, inability to access their own records due to poor record keeping by providers, and long wait lists to receive services. Issues with cost and eligibility criteria, language access, and unpleasant professionals and long wait lists, all speak to the lack of services and/or capacity of existing services to meet the needs of community members, especially those from different cultures.

“...even if everyone wished to go into treatment, there is not nearly enough to go around.”

Beyond the specific access issues just discussed, a couple of the focus groups spent time discussing how the existing political, legal, educational, and social systems also serve as barriers to service access. One focus group felt that the heavy police presence in some neighborhoods is very debilitating; and, that the “top down” political barriers make advocating for certain populations difficult. Another focus group felt that often the “zero tolerance” policy in schools does not consider the mental health of the youth and results in youth going to jail instead of being assessed and receiving mental health services first. That youth are incarcerated without addressing their social and emotional well-being speaks directly to the lack of knowledge, not only among community members but also among public agencies, as to what mental health services are available and where. Focus

group participants advocated for outreach that educates communities and systems about mental health prevention and early intervention.

Other barriers to service access cited by focus group participants included:

- Lack of community resources to provide needed services.
- No time to access services because family members are working two, and sometimes three, jobs.
- Peer pressure to not access and engage in services, because of the lack of confidence in its benefits.
- A shortage of psychiatrists that specialize in working with young people, resulting in lack of follow-through on the part of the consumer.

Table 9: Barriers to Service Access

Access Barriers	Number of Mentions
Access Issues	31
• Stigma and Discrimination	8
• Geographic Location/Social and Physical Conditions/Transportation	5
• Cost/Insurance/Medi-Cal/Eligibility Criteria	4
• Service Linguistic/Cultural Competency	4
• Service Operations	4
• Available Services/Capacity	4
• Trust	2
Political/Legal/Educational/Social Systems	7
Outreach/Education/Awareness	6
• Available Services	3
• General	2
• Target Populations	1
Funding and Resources	2
Families/Parent High Stress Levels/Parenting Issues/Poor Social Skills/Coping	1
Service Engagement/Benefits	1
Service Integration/Continuity of Care	1

Strategies to Increase Access (Q8)

As a follow-up to the question about service barriers, focus group participants were asked to discuss the types of strategies that would help people obtain access to the services they needed (see **Table 10**).

The focus group participants underscored a two-pronged approach to breaking down the service access barriers discussed in the previous section. On one front, they underscored the importance of outreach, education, and awareness efforts, and on the other front they pushed for addressing specific access issues.

With respect to outreach, education, and awareness the focus groups suggested conducting educational campaigns about mental health treatment and support services to increase public knowledge and awareness. They proposed employing advertising, such as billboards; technology, such as appropriate web sites on the Internet; print materials, such as brochures; and, television. In addition, they emphasized that whichever medium was used, the message needed to be in multiple languages. One focus group suggested conducting outreach on the Pilipino Channel, and translating brochures into multiple languages. Another focus group was concerned about the message itself, and suggested reframing the words “mental health” to overall “well-being” instead, thereby normalizing and de-stigmatizing the message. A couple of the focus groups added that some of these efforts should involve the churches and direct their attention to the community’s youth.

“There needs to be more attention to the cultural issues that may be at play that keep people from seeking help or from being successful when accessing services.”

To further address access barriers, focus groups discussed recruiting and hiring culturally and linguistically competent staff, offering alternatives to traditional treatment models, providing more user-friendly services that honor confidentiality, and making available transportation or bus tokens to those who need it. One focus group suggested locating services at faith-based organizations that are trusted among community members.

Other strategies for increasing access cited by focus group participants involved the following:

- Involving consumers in the mental health process by giving them a voice in resource allocation, enabling them to take ownership of harm reduction and other programs, and providing additional encouragement or incentives to those who are engaged in services.
- Cultivating partnerships among agencies, but also with community members.
- Developing effective advocacy and referral networks.
- Recognizing programs that honor consumer willingness and readiness to access and utilize services.
- Making harm reduction services a priority.

“We need to figure out how to get the community and agencies on the same page and develop more positive partnerships; partnering with consumers and community members ”

Table 10: Strategies to Increase Access

Strategies to Increase Access	Number of Mentions
Outreach/Education/Awareness	13
• Specific Mediums	4
• Linguistic/Culturally Appropriate Messaging	4
• General	3
• Specific Locations	1
• Target Populations	1
Access Issues	8
• Service Operations	2
• Service Linguistic/Cultural Competency	2
• Cost/Insurance/Medi-Cal/Eligibility Criteria	1
• Available Services/Capacity	1
• Geographic Location/Social and Physical Conditions/Transportation	1
• Stigma	1
Community/Client Involvement in the Mental Health Process	3
Collaboration/Partnership/Teams	2
Referral Network	2
Service/Treatment Effectiveness/Acceptance/Utilization	2
Immigration and Cultural Matters	1
Other	3

IX. Recommendations for Informing Communities about PEI

Recommendations

When focus group participants were asked to provide recommendations on how to let people know about prevention and early intervention services, they focused almost entirely on various means of outreach, education, and awareness (see **Table 11**). Aside from outreach, education, and awareness, the only other mention concerned developing partnerships with the Immigration Department and school districts, such as the Los Angeles Unified School District, as a means of reaching a broader audience when communicating about prevention and early intervention services.

With respect to the specific types of outreach, education, and awareness efforts for prevention and early intervention mental health services, specific mediums and locations were heavily discussed, followed by the need for linguistically and culturally appropriate messaging, information on available services and how to access them, and specific populations that should be targeted.

The focus groups recommended a number of different means by which outreach and education about mental health services should be delivered, including the following:

- Paper media such as flyers, posters, and stickers;
- Electronic media such as blogs, websites, MySpace, and Facebook;
- Television;

“Advertisement and outreach activities which breakdown stigma are needed.”

- Radio;
- Hotlines;
- Musical events;
- Employers and businesses; and,
- Celebrity spokespeople.

Locations at which to conduct outreach, education, and awareness efforts included local community settings such as schools, faith-based organizations, and community centers. In addition, focus group participants considered existing organizations that are likely to have a broader reach beyond the immediate community, such as public agencies like the post office, Department of Social Services, juvenile justice camps, prisons, and current service providers. One focus group, Homeboy Industries, considered itself a location at which outreach, education, and awareness should take place.

On a smaller scale, focus group participants also indicated that outreach, education, and awareness efforts need to be culturally and linguistically appropriate. In addition to culturally and linguistically appropriate messaging, participants emphasized that the message needs to let people know which services are available and where to find them, as well as educate them about what it means to be mentally healthy.

Table 11: Recommendations for Informing Communities about PEI

Recommendations	Number of Mentions
Outreach/Education/Awareness	31
• Specific Mediums	14
• Specific Locations	10
• Linguistic/Culturally Appropriate Messaging	3
• General	2
• Available Services	1
• Target Populations	1
Collaboration/Partnerships Teams	2

X. Summary

The participants in the six focus groups representing Service Area 4 have had limited experience with or participation in the PEI Planning Process. Of 50 focus group participants, nine had participated in the PEI Planning process in the form of serving on Ad Hoc Committees, attending Service Area Advisory Committee (SAAC) meetings, and participating in informational meetings.

When asked to select the priority populations they represent, the majority of participants represented the following three: Trauma-exposed individuals (64%), Children at-risk of school failure (62%), and Children and youth in stressed families (60%). When prioritizing mental health needs, participants considered Psycho-social impact of trauma a top mental health need, and Disparities in access to mental health services and Stigma and discrimination secondary mental health needs.

All three priority mental health needs were reflected in the participants' discussion about community impacts. One of the most highly mentioned community impacts was community and family violence and abuse, with high incidence of gang activity, kidnapping, vandalism, rape and child abuse.

Community and family violence and abuse were followed by concerns about how stigma and discrimination contribute to the disparities in accessing mental health services.

Stigma and discrimination was also cited as a top barrier to service access. According to participants there is a general fear of receiving services which manifests itself in the following ways: the shame of being labeled “crazy,” the fear of being denied services, the fear of encountering someone who might recognize them, the fear of becoming dependent on psychotropic medication, and the fear of social prejudice.

Strategies for reducing stigma, and thereby increasing access, focused on a two-pronged approach. On the one front, participants underscored the importance of outreach, education, and awareness efforts, and on the other front they pushed for addressing multiple access issues directly. Participants emphasized that whichever medium was used, the message itself needed to be reframed to promote overall well-being, thereby normalizing and de-stigmatizing “mental health.” To further address access barriers, focus groups discussed recruiting and hiring culturally and linguistically competent staff, offering alternatives to traditional treatment models, providing more user-friendly services that honor confidentiality, and making available transportation or bus tokens to those who need it.

Needed priority prevention services centered on: 1) supporting programs for parents; 2) offering counseling services; 3) preventing gang involvement; 4) providing housing; and, 5) delivering services at no or low cost to the general public, making sure that undocumented immigrants have access. Needed priority early intervention services focused on: 1) providing age-appropriate services; 2) engaging DCFS; 3) offering parenting classes; 4) establishing community support groups and 12-step programs; 5) making use of police services; 6) developing a housing first model that include comprehensive support services; and, 7) creating social spaces for consumers. The most popular recommended locations at which to provide needed prevention services were schools. Only one focus group identified locations for early intervention services which included hospitals and its own agency.

APPENDIX A

APPENDIX A: Focus Group Guide

FOCUS GROUP QUESTIONS

Issues	Focus Group Questions
PEI Planning Process	1. Have you or your group taken part in the Los Angeles County Department of Mental Health's (DMH) Prevention and Early Intervention (PEI) planning process? If so, how?
Participants' Organizational Affiliation	<p>These focus groups help us learn more about the types of mental health services and resources that are needed to support the social and emotional well-being in your community and among other groups of people in L.A. County.</p> <p>2. Which region or area in L.A. County do you represent or will you be talking about in today's discussion?</p> <p>2a. Of the identified priority populations [<i>facilitator refers/points to visual aid listing priority populations</i>], which of these groups of people do you represent?</p>
Community Mental Health Needs	<p>The California State Department of Mental Health said that the Prevention and Early Intervention (PEI) plan should focus on the needs of the following groups: at-risk youth, people who may be at risk of suicide, people who haven't been able to get services, and people who have experienced trauma, stigma and discrimination.</p> <p>3. What needs are most important to the group of people you represent?</p> <p>3a. <i>Of the needs that you've listed, which are the top three needs most important to your community?</i></p> <p>4. What do you see happening in your community because of these needs? (what problems are occurring?)</p>
Prevention and Early Intervention Services	<p>As we talked about earlier, there is a difference between prevention and early intervention services [<i>facilitator refers/points to visual aid defining prevention and early intervention</i>].</p> <p>5. What prevention services or resources are currently available in your community or among the group of people you represent?</p> <p>5a. What prevention services or resources are needed?</p> <p>5b. <i>"Of the prevention services you've listed, which are the top three needed."</i></p> <p>5c. <i>Facilitator probes for information on locations for services.</i></p>

APPENDIX A: Focus Group Guide

Issues

Focus Group Questions

6. What **early intervention** services or resources are currently available in your community or among the group of people you represent?
 - 6a. What **early intervention** services or resources are needed?
 - 6b. *Of the early intervention services you've listed, which are the top three needed in your community?*
 - 6c. *Facilitator probes for information on locations for services.*
7. What keeps people from getting the prevention and/or early intervention services they need?
8. What types of things or strategies would help people get the services they need?

*Long Range
Planning*

9. What recommendations do you have for how to let people know about prevention and early intervention services?
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